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ABSTRACT

Counseling victims of incest is based on the needs of each client. Different types of trauma may differentially affect four main areas of the victim's life: social, emotional, physical, and sexual. Each of these areas merits exploration in counseling, with emphasis varying with the nature of the circumstances surrounding the incestuous relationship. It is particularly important for the counselor to be nonjudgmental and to provide a psychologically safe environment. Assumptions made about working with victims also need to be addressed. These include counselor attitudes or biases and recognition of the numerous myths surrounding incest. Research indicates that most incest victims share some common characteristics, especially in terms of reactions to the assault and presenting complaints in counseling. Furthermore, general treatment issues include an assessment of the nature of the assault (duration, frequency, and type of sexual contact), precipitating factors in the decision to disclose the incest, and the unique response pattern of the victim. Case material is presented and the issue of working with incestuous families is addressed briefly. (Author)

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PSYCHOLOGICAL INTERVENTION IN CASES OF INCEST:

TREATMENT ISSUES

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Treatment Issues in Working with Victims of Incest

My first experience of working with an incest victim occurred three years ago. I was conducting a routine history-taking session with a woman who I was seeing in conjoint counseling. In a matter of fact manner Jackie began to tell me of her incestuous relationship with her father, one which resulted in her being pregnant at age 14. Subsequently she began living with her mother and the mother's boyfriend. During one particularly violent family argument Jackie came to her mother's defense and shot and killed the lover. She was sent to a juvenile home and soon thereafter delivered a child afflicted with muscular dystrophy.

My response to this tragic chain of events was powerful and emotional. I was shocked, overwhelmed, full of rage, and filled with a sense of admiration for the woman who sat in front of me. Congruent with Giaretto's(1976) observations, I was presented with a significant challenge to explore my own attitudes and feelings regarding incest. I believe that I reacted naturally to Jackie's experience but remember a special appreciation for her patience with me as I learned to cope with the magnitude of her pain. It took me a while to begin seeing her again as a person and not just a victim. In particular I had to accept the violence that her whole situation represented; accept that it is real and can happen to anyone.

My presentation today will focus on the following topics: assumptions about working with incest victims, victim characteristics, general counseling issues, case material dealing with special issues in therapy, working with groups of incest victims, and treating incestuous families.

Initially, I would like to clarify some of the assumptions I hold about working with victims of assault, including those of incest. First, I believe that no one

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has the right to assault. Secondly, I believe that there is a mythology which surrounds the topics of rape and incest, especially concepts such as the "Lolita syndrome" and the myth of consent(Rush, 1971). Gager and Schurr(1976) are of the opinion that these interpretations are not conclusive of anything except perhaps the sexual orientation of the observers. Additionally, I feel that counselors must recognize the intense pain of dealing with the experience, both for themselves and for their clients. Finally, we must recognize the broad impact that an incest experience can have on an individual's life, affecting social, emotional, physical, and sexual components of their functioning.

The majority of my experience has been working with women who reported childhood or adolescent cases of incest while being in therapy for other presenting problems. They were all 18 years or older at the time therapy was initiated. The age range of occurrence of their first incestual experience was 10-16 years. Their presenting problems included: depression, low self-esteem, acting out behaviors (prostitution, violence towards self and others), difficulties in current relationships(sexual and communication problems), poor social skills, sexual identity(preference) issues and confusion, guilt feelings, and free-floating anxiety. Other presenting problems cited in the literature that can indicate unresolved issues related to an incest experience include: frigidity, nymphomania, homosexuality, alcoholism, and drug abuse.

There are several general issues to be considered in counseling incest victims. Treatment should be based on the issues raised by the nature of the assault and the victim's unique response pattern (e.g. expressed, controlled, silent, compounded). Secondly, there is a set of counselor attitudes and behaviors which appear to be facilitative of successful counseling. These include: acceptance, empathic understanding, non-judgmentalness or evaluativeness, support, optimism, and compassion.

Following the establishment of a trusting and supportive environment there are four main goals of therapy to be pursued (Giaretto, 1976). They are parallel in process rather than sequential. Emotional catharsis involves facing and working through one's feelings regarding the incest experience rather than being encouraged to deny and repress these feelings. The goal of confrontation-assimilation promotes self-knowledge and acceptance through awareness of immediate feeling states. The process of self-identification consists of internalizing a positive self-concept. Following principles of psychosynthesis, this includes the recognition that the self is more than the changing functions of mind, body, and spirit: "the whole is larger than the sum of the parts." Finally, the self-management phase occurs when one's past and present experiences are in one's conscious awareness and available to use in achieving personal growth. The will can thus be applied towards achieving positive change.

These goals may be reached through the use of a variety of counseling strategies and approaches. Gestalt exercises can encourage identification of feelings, body awareness, and spontaneous expressions of these feelings. Methods taken from psychosynthesis such as the use of guided imagery can uncover repressed material and present new ways of integrating these thoughts and feelings in the present. A more psychodynamic approach involving appropriate interpretations, for example, may also be helpful in supporting the client's exploration process.

There are special counseling considerations in working with victims of the immediate past. Primarily, the counselor will be working with an individual experiencing a crisis reaction. Furthermore, the counselor may need to provide information or aid the client in contacting the appropriate community agencies. In some cases the counselor may assume an advocacy role in dealing with insensitive bureaucracies and officials. He/she may also help the client develop problem-solving strategies to deal with immediate needs (e.g. financial, medical, safety). With

child victims in particular the crisis reaction may focus on physical pain and a sense of invasion of privacy rather than the sexual nature of the crime. Medical attention and physical reassurance is very appropriate at this stage.

For victims of incest and assault in the distant past, other issues may assume more importance in counseling. The counselor must appreciate the magnitude of what it has been like for the client to keep a secret like this for such a long time. On the other hand, if she did talk with anyone previously about it, the counselor needs to assess the response she received from significant others and the agencies where the incest was reported. Additionally the counselor must develop a sense of the extent of the client's repression and denial, and proceed appropriately, at the pace of the client. Furthermore, I believe that the counselor should make an attempt to assess and understand the coping strategies chosen by the victim as a result of her experience. For example, some of the behaviors identified as characteristic of some women who have had incest experiences include promiscuity, homosexuality, antisocial behaviors, hysterical personality traits, and schizoid personality. It is possible to view some of these behaviors as adaptive and positive choices made by these women to survive such traumatic psychological experiences. The counselor can then aid the client in identifying conflicts she wishes to resolve or behavior changes she wants to achieve related to these "adaptive" choices. Finally, and most importantly, the counselor must be available and willing to deal with the issues of self-esteem and complicity. The likelihood that they will be major concerns of the client is very high.

I would like to conclude this section on individual counseling with incest victims by mentioning briefly some related issues that may arise in therapy. Rush (1971) notes that victims are usually held responsible for precipitating the incest, or else the blame is laid on the mother for condoning, ignoring, or encouraging the incestual contact. She states that we must remember that children usually have no

where to go outside of the family; no options, no choices, no power. It may also be helpful to view the child as a victim of poor parenting. Unfortunately, the focus may more often be on the child's "seductiveness" or complicity. In cases where that arises, it may well be true that she was seeking some form of attention and affection. However, I believe that by definition the roles of parent and child are unequal and different; a child cannot be a full, consenting partner in a sexual "relationship." Thus this crossing of generational boundaries is not only inappropriate and dysfunction but also corresponds with my definition of rape. Gager and Schurr (1976) discuss reasons why children are often silent about their involvement in an incestual relationship. They believe that little girls, like their mothers before them, learn at an early age to endure being sexually used. Macdonald (1971), on the other hand, interprets the silence to mean that "the experience is not without its satisfactions." He suggests that girls decide to report the behavior only when they are prevented by their fathers from dating boys, are punished by their fathers, or when a father turns his attention to a younger child. One of the most frustrating elements of both professional and societal response to incest victims is the labeling that is encouraged. Victims are categorized by one author (Schultz, 1975) as collaborative, non-objecting, encouraging, fully participating, and seductive. He concludes by stating that the "effects of victimization are exaggerated." Kiefer(1973) takes this line of reasoning even further and urges the physician or counselor to not overreact. He suggests that the child is acting normally ("seductively") and will grow out of her need for affection. Armstrong (1978), on the other hand, urges counselors to recognize and support the need many women have to confront their fathers as to why the incest happened and to ask their mothers why they did not move to stop it. By now it should be clear that there are many conflicting opinions and biases discussed in the literature regarding the treatment of incest victims. I believe that we must confront those that are destructive and mythological in order to fulfill our obligation of provid-

ing humanistic and sensitive treatment.

Group treatment of incest victims has also been described as an alternative to individual therapy. James (1977) developed an eight session program for use with adolescent girls in a juvenile treatment center. Role-playing was encouraged as the young women focused on the following topics: what I feel now about the person who molested me; what I feel motivated the person to molest me; how I feel towards males in general as a result of the incest; how I feel about rape, including father/stepfather or any other rape that has happened since; how I feel about telling someone else about the incest and how often I talk about it; and my self-image and what things I feel sensitive about as a person.

I would like to talk briefly now about three specific individuals whom I have worked with in therapy who have had incest experiences. I have chosen these examples because I see them as each being at a different place along the continuum of severity of adjustment problems and availability for gaining something positive from counseling.

Dianne was referred to me by a physician because of a chronic skin rash and general nervousness that he felt was caused by psychological concerns. In the intake interview she stressed problems such as poor communication with her husband, anger at herself for being sexually unsatisfying to him, and chronic agitated depression. She then revealed an incestual relationship with her father which began when she was 12 years old and continued sporadically for approximately three years. Dianne felt that this might have "something" to do with her current problems but explained that her father had wanted to help her by teaching her about sex "the right way." Dianne was unwilling to explore this topic much further. Her anger and guilt was so deeply repressed that counseling about that issue would have been fruitless. She participated in short-term conjoint counseling with her husband and their main focus was communication patterns.

Cathy was at quite a different place. She had been molested by her father at age 14 and institutionalized soon thereafter for an acute schizophrenic break. She remained there for 4 years and then lived with her mother for 2 more years until she began college. At the time that I first saw Cathy she was 29 years old and pursuing a master's degree. She was very lonely, depressed, and had no sense of positive self-worth. Since her sexual abuse as an adolescent she had come to believe that that was the only way she deserved to be treated. Cathy prostituted herself and became involved in both heterosexual and homosexual relationships where her role was almost one of servitude. Through a long process of intensive counseling she began to rebuild her sense of self-esteem and to learn that she could have friends without sexualizing the relationship and demeaning herself. One of the turning points in therapy was her announcement that she wanted to "divorce" her family for not believing her when she revealed the incest. This appeared to free her from so much stored up anger that had kept her from trusting people. She was also able to disidentify from her aggressors and become less afraid of acting on the latent violence that had characterized so many of her previous relationships.

Jackie, the woman mentioned in the introduction of this presentation, is the third case I would like to mention. She was a gay woman who I saw in conjoint counseling with her partner and another counselor. Their relationship was one of deep and positive commitment. They sought counseling to improve their communication patterns and open the way for more intimacy. Jackie had really moved beyond her early incest experience and had resolved many of her feelings about it. At issue was helping her partner understand and accept it as part of Jackie's past, instead of being frightened or repulsed by it. Part of counseling was exploring the myths we all held about incest at the time and then being able to let go of them.

I would like to close with a brief examination of some of the issues discussed in the literature regarding the treatment of incestuous families. Family therapy may not always be useful immediately; it may be more appropriate to start work with individuals, move to pairs, and then end up with the family group. Eist and Mandel (1968) encourage family therapy as a way to work through feelings and disrupt the destructive relationship patterns which primarily precipitated the incest.

Giarretto, in his work with the Child Sexual Abuse Treatment Program, has developed one of the most comprehensive models for treating incestuous families. It is based on the same general format as that for working with individuals (catharsis, self-assessment/confrontation, self-identification, and self-management) and is basically a family systems approach. He believes that a distorted homeostasis(family balance) is evidenced by certain symptoms, one of the most extreme being incest. He also suggests that the marital relationship is the key factor in maintaining family balance. High self-concepts are necessary for positive marital relationships and raising children with positive self-concepts. Individuals with low self-esteem tend to engage in hostile/aggressive behavior. They are angry, disillusioned, and often feel as though they have little to lose. When these individuals, especially incestual fathers, are punished in a de-humanizing institution, the low self-concept/high destructive energy system is reinforced.

Giarretto believes that the goal of family counseling should be to alleviate the emotional stresses of the experience and the punitive actions usually taken by the community. Self-awareness and management should be enhanced and an effort should be made to promote family unity, growth, and a sense of responsibility to society. The key to his program is the acceptance by the parents of their role in the family's activities, especially the father accepting responsibility for

behaving inappropriately. Each member is asked to examine his/her role, behaviors, and feelings. The goal is to restore appropriate generational boundaries and achieve homeostasis.

Pittman (1976) describes a similar model with one major modification. He suggests that the problem of incest in the family should be defined along four dimensions. Concerning the first, whether the incest is real or imagined, he suggests that the charge should always be taken seriously because even if it is imagined the misdirected sexual tensions, sense of sexual threat, and breach of generational boundaries are real. The next parameter is whether the incest is covert or overt. For the problems to be resolved at least three people must be involved: the victim, the accused, and the displaced person. The greatest destructiveness occurs when the child must maintain the guilty secret. The third dimension is whether the incest is unique or habitual. Finally, it must be determined whether it is structural or incidental. Incest of long standing and frequent repetition most often occurs in a pathological family and will require more intensive and long-term therapy.

In summary, I have attempted to present some of my own and others' ideas concerning therapy with victims and incest and their families. My bias is to promote a more humanistic and open approach to dealing with what has long been considered a dark and painful secret.

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